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In the
Supreme Court of the United States

OCTOBER TERM, 1996

**DENNIS C. VACCO, ATTORNEY GENERAL OF THE
STATE OF NEW YORK, et al.,**

PETITIONERS,

v.

TIMOTHY E. QUILL, M.D., et al.,

RESPONDENTS.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE SECOND CIRCUIT

STATE OF WASHINGTON, et al.,

PETITIONERS,

v.

HAROLD GLUCKSBERG, M.D., et al.,

RESPONDENTS.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE NINTH CIRCUIT

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IN SUPPORT OF RESPONDENTS**

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BRIEF AMICUS CURIAE OF LAW PROFESSORS
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INTEREST OF THE AMICI CURIAE

Amici are professors of law who lecture, write, and provide legal counsel in the areas of Constitutional Law, Criminal Law, and the field of Law, Medicine and Bioethics. *Amici* have widely diverse perspectives but are united in the convic-

tion that this Court should affirm the lower courts' decisions on the ground that the current regime of regulation of physician-assisted suicide represents a thoroughly irrational means for attempting to protect patients from abuse. Rather than protecting patients, the current legal regime actually encourages abuse. In addition, the current regime leaves individual physicians and other health care professionals uncertain as to which of their actions may be found illegal and whether they will have their lives destroyed by an exercise of prosecutorial discretion. *Amici* have filed this brief because of their concern that, for the foregoing reasons and the reasons set forth in their brief, the statutory schemes at issue here undermine respect for law, the rule of law, and the democratic process.

SUMMARY OF ARGUMENT

The State regimes overturned by the lower courts were properly found unconstitutional. Broad distinctions between physician-assisted suicide, on the one hand, and "letting patients die," on the other, are no longer rationally employed by the States to protect patients from abuse. Indeed, they are currently employed in a fashion which exacerbates the risk of abuse. Thus, these regimes are no longer rationally related to the purposes which Petitioners claim they were designed to advance.

Because the law has not kept pace with developments in medical technology, state courts have increasingly carved out exceptions to assisted-suicide laws so as to accommodate the needs of health care personnel and their suffering patients. The exceptions have by this time left little of the rule. In addition, increasing numbers of medical personnel regularly exceed the limits of these exceptions to provide covert assistance in suicide to suffering patients. Little attempt, if any, is made to uncover and prosecute these instances of physician-assisted suicide.

This regime exposes patients to greater risk of abuse than

they would be subject to under a regime of legalized and regulated physician-assisted suicide. As the available literature demonstrates unequivocally, physician-assisted suicide takes place irrespective of whether it is legally permissible or not. To the extent that it is kept strictly criminal, the acts are performed "in the closet" — leaving individual health care professionals to make critical decisions without oversight, without regulation, and without the participation of other health care personnel. On the other hand, to the extent that it is permitted to be practiced on the theory that the physician is "just letting a patient die," individual health care professionals are again left without adequate oversight, regulation, and participation from other health care personnel. By maintaining a broad distinction between merely "letting a patient die" and physician-assisted suicide, the State regimes take (and encourage others to take) decisions to engage in the former much less seriously than decisions to engage in the latter.

Should the decisions below be reversed, important interests will suffer. In addition to being placed at increased risk of abuse, patients will be handicapped in finding adequate relief from inhumane and unnecessary burdens in the dying process. Health care professionals will be forced to operate under legal uncertainty — not knowing whether a particular decision amounts to permissible withholding of life support or impermissible assistance in suicide. Finally, a reversal would undermine the overarching interests of the State in preserving respect for law and the rule of law, and its interest in the proper functioning of democratic processes.

ARGUMENT

THE STATE REGIMES OF REGULATION OVERTURNED BY THE LOWER COURTS ARE UNCONSTITUTIONAL BECAUSE THEY HAVE BECOME IRRATIONAL MEANS FOR ADVANCING THE STATE INTERESTS THAT ARE ALLEGED TO JUSTIFY THEM.

The State legislative regimes involved in these cases violate the Fourteenth Amendment to the United States Constitution because they bear no rational relation to the advancement of the State interests that have been put forward in support of these regimes. *See Allegheny Pittsburgh Coal Co. v. County Comm'n of Webster County*, W. Va., 488 U.S. 336 (1989); *see also Clark v. Jeter*, 486 U.S. 45 (1988); *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432 (1985).

The Solicitor General, in the brief he has submitted in No. 96-110, argues that it is the State interest in protecting the many patients who might be abused if physician-assisted suicide were to be legalized that justifies burdening the liberty interests of the few patients who are forced to suffer when that option is denied them. Br. of Solicitor General at 18-19. In No. 95-1858, he argues that the same interest justifies the distinction that the States maintain between "letting nature take its course," on the one hand, and "physician-assisted suicide," on the other. Br. of Solicitor General at 9. Although the Petitioners and the *amici curiae* who have filed briefs on their behalf make this point in a variety of ways, they are essentially in agreement with the Solicitor General that it is the threat of the abuses that might follow legalization that justifies holding the line against physician-assisted suicide.

However, in drawing the line as they do in prohibiting physician-assisted suicide, the States are actually exacerbating the risks of abuse of patients. Rather than bearing a rational relation to the goal of protecting patients from abuse, the State legislative regimes found unconstitutional by the Courts of Appeals for the Second and Ninth Circuits actually expose

patients to a greater risk of abuse than would be faced under a regime that permitted and regulated physician-assisted suicide.

A. *The current regimes no longer make any rational use of the distinction between physician-assisted suicide and refusal of life-prolonging treatment.*

It is no surprise that State court judges deciding the first "right to die" cases felt it necessary to develop a bright line distinction between suicide and refusal of treatment. The law had not kept pace with developments in medical technology that had created situations where continuation of life-prolonging treatment could seem senseless and even cruel from the point of view of the patient, the patient's family, and the medical personnel involved. Criminal laws regarding homicide and assisted suicide did not make exceptions for cases where the patient begged for death.

In an environment of legislative inactivity on the subject, common law courts acted to provide relief in individual cases in a fashion that would not obviously conflict with the then-governing law. In *Matter of Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), for example, the Supreme Court of New Jersey was asked to authorize the removal of a patient from a ventilator so that she could die rather than be forced to continue to exist in a persistent vegetative state. No evidence was introduced that Karen Quinlan would have felt mechanical ventilation to be a particularly intrusive or offensive medical technique. Presumably she would have been willing to be maintained on mechanical ventilation so long as it promised a future in which she would have preferred life over death. But Ms. Quinlan's father thought she would rather be dead than be maintained in a persistent vegetative state. In granting the right to remove her from the ventilator so that she could die, the New Jersey Supreme Court noted the fact that many might see this as an act of assisting suicide. In reply, all the court could muster was one sentence: "We would see,

however, a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance, in the face of irreversible, painful and certain imminent death." *Id.* at 43, 355 A.2d at 665.

Similarly, in *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977), the Supreme Judicial Court of Massachusetts felt it necessary to draw a bright line between physician-assisted suicide and termination of life-sustaining treatment on request. Again, the court gave short shrift to the effort to justify this distinction. In an important footnote, the court said:

The interest in protecting against suicide seems to require little if any discussion. In the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide since (1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death. Furthermore, the underlying State interest in this area lies in the prevention of irrational self-destruction. What we consider here is a competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life. There is no connection between the conduct here in issue and any State concern to prevent suicide.

Id. at 743, n.11, 370 N.E.2d at 426, n.11 (citations omitted).

The *Saikewicz* case itself involved a cancer patient whose life would have been extended for only a short period by chemotherapy. The treatment did not offer any hope of cure, and, in recognizing Mr. Saikewicz's right to refuse chemotherapy, the court claimed that his death was

"inevitable" in the sense that the treatment was only "life-prolonging" and not "life-saving."

In later cases, however, the Massachusetts courts extended the right to refuse treatment to embrace situations where treatment was clearly to be classified as "life-saving." For example, in *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978), a patient was permitted to refuse amputation of a gangrenous leg despite the fact that the amputation would have extended her life indefinitely. In *Commissioner of Correction v. Myers*, 379 Mass. 255, 399 N.E.2d 452 (1979), the Supreme Judicial Court stated in dictum (and later held in *Matter of Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980)) that patients had the right to refuse life-saving kidney dialysis. In *Lane* and *Spring*, the opinions made no effort to explain how the refusals of life-saving treatment differed from suicide. In *Myers*, the court said only that Myers death "from a refusal of medication or dialysis [would not] necessarily constitute suicide. Rather, his death would result from 'natural causes' since he would not have 'set the death producing agent in motion' with the 'specific intent' of causing his own death." 379 Mass. at 262, 399 N.E.2d at 456.

In *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986), the Massachusetts court took the next step and recognized a right to refuse life-maintaining treatment where the "specific intent" of the patient was to cause his own death. There, the Supreme Judicial Court recognized the right of Paul Brophy to refuse food and water in order to end his continued existence in a persistent vegetative state. Doctors supplied food and water to Mr. Brophy by way of a gastrostomy tube inserted through the wall of his stomach. As with Karen Quinlan, there was no evidence that Paul Brophy would have objected to this as a particularly intrusive or offensive medical technique. Like Ms. Quinlan, he would likely have been willing to be maintained in this fashion if it had offered him a future in which he would have preferred life over death. But the evidence showed conclusively that Mr. Brophy would rather die than persist in a

vegetative state. He had frequently, clearly, and vehemently stated his objections to being kept going in a state like Karen Quinlan's. "If I'm ever like that," he once told his brother, "just shoot me, pull the plug." *Id.* at 428 n. 22, 497 N.E.2d 632 n. 22. Upon admission to the hospital, he had stated to one of his daughters, "If I can't sit up to kiss one of my beautiful daughters, I may as well be six feet under." *Id.* As a result, the court granted him the right to die by dehydration and starvation.

Three dissenters in the *Brophy* case highlighted the tension that existed between the court's holding and laws prohibiting assistance in suicide. Justice Lynch's observations on the point are representative:

Here, Brophy is not terminally ill, and death is not imminent, and the judge specifically found that Paul Brophy's decision would be to terminate his life by declining food and water. The judge also found that "Brophy's decision, if he were competent to make it, would be primarily based upon the present quality of life possible for him, and would not be based upon the burdens imposed upon him by receiving food and water through a G tube, which burdens are relatively minimal. . . . Where treatment is burdensome and invasive, no such specific intent is normally at issue because, whether or not the patient seeks to die, the patient primarily seeks to end invasive or burdensome treatment. There is no question that the intent here is to end a life that is "over." Moreover, death here would not be from natural causes, i.e., causes he or his agents did not set in motion, but instead, the death producing agent would be set in motion by a volitional act with the intent to cause death.

Suicide is primarily a crime of commission, but can, and indeed must, also be conceived as an act of omission at times. *See In re Caulk*, 125 N.H. 226, 228, 231-232, 480 A.2d 93 (1984) (suicide can be committed by starvation [or dehydration]). If nutrition and hydration are ter-

minated, it is not the illness which causes the death but the decision (and act in accordance therewith) that the illness makes life not worth living. There is no rational distinction between suicide by deprivation of hydration or nutrition in or out of a medical setting — both are suicide.

Id. at 446-47, 497 N.E.2d 642-43 (footnotes omitted).

What has been done in Massachusetts and New Jersey has been done across the country. *See Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 271-77 (1990) (citing, among others, New York and Washington cases). State courts have essentially legalized some forms of physician-assisted suicide in order to adjust the law to the realities of modern medical technology and to provide relief to suffering patients, their families, and their medical personnel. In doing so, the courts and the medical personnel who have followed their decisions have continually developed ingenious ways to grant relief while preserving the appearance of not sanctioning suicide.

Recently, medical personnel have begun to engage in a practice called "terminal sedation." Patients who are not in a persistent vegetative state — who are conscious and competent but suffering from a terminal illness — are offered the option of being sedated to complete unconsciousness and being allowed to die of dehydration, starvation, or some intervening complication. *See* J. Andrew Billings & Susan D. Block, *Slow Euthanasia*, 12 J. Palliative Care (forthcoming 1996); Katherine M. Foley, *Pain, Physician-Assisted Suicide and Euthanasia*, 4 Pain Forum 163 (1995); I. R. Byock, *Consciously Walking the Fine Line: Thoughts on a Hospice Response to Assisted Suicide and Euthanasia*, 9 J. Palliative Care 25 (1993); N. I. Cherney and R. K. Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. Palliative Care 31 (1994); R.D. Troug, et al., *Barbiturates in the Care of the Terminally*

Ill, 327 N. Eng. J. Med. 1678 (1991).¹ With the advent of such techniques of "refusing treatment" as "terminal sedation," very little seems left to the category of the sort of physician-assisted suicide that is still to be deemed a crime. What does remain seems to serve only as a foil for legitimating everything else that has been allowed. "Physician-assisted suicide," so-called, has become merely a symbol — the thing that every new technique for hastening death claims not to be in order to establish respectability.

Moreover, even those acts that are thought still to constitute prohibited physician-assisted suicide are regularly practiced in the United States. In March 1996, the Journal of the American Medical Association published an article documenting that physicians in the State of Washington commit acts of physician-assisted suicide and euthanasia in percentages that rival those in Holland, where euthanasia and physician-assisted suicide are essentially legalized. See Anthony L. Back, et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919 (1996):

Washington physicians receive requests for physician-assisted suicide or euthanasia almost as frequently as Dutch physicians. Also, physicians in both places grant approximately the same proportion of requests. Our study indicates that in Washington, 24% of patient requests for physician-assisted suicide or euthanasia are ultimately granted; in the Netherlands, less than a third of requests are ultimately granted. Of course, Washington differs from the Netherlands in at least two salient respects, namely, the criminal status of physician-assisted death and the absence of universal health

¹ See also, Warren Wolfe, *Three lives, three journeys: Ken/A life, a death, a legacy*, Minneapolis Star Tribune, Feb. 27, 1994, at 14A (describing sixty-two year old, competent nursing home resident who dehydrated and starved himself to death with comfort care provided by nursing home staff).

coverage. However, these empirical comparisons suggest that patients in both places make these requests regardless of legal constraints on physicians or medical care delivery systems.

Id. at 924 (footnotes omitted).

As regards the extent to which these results are extrapolatable to the United States as a whole, the authors cited surveys conducted in four other states — D. J. Doukas, et al., *Attitudes and Behaviors on Physician-Assisted Death: A Study of Michigan Oncologists*, 13 J. Clin. Oncology 1055 (1995); R.S. Shapiro et al., *Willingness to Perform Euthanasia: A Survey of Physician Attitudes*, 154 Arch. Int. Med. 575 (1994); S.H. Miles, *Physicians and their Patients' Suicides*, 271 JAMA 1786 (1994); and M.A. Lee, et al., *Legalizing Assisted Suicide — Views of Physicians in Oregon*, 334 N. Eng. J. Med. 315 (1996) — and conclude that their data "do not suggest that a uniquely favorable degree of support exists for physician-assisted death in Washington." Back, et al., 275 JAMA at 924-25.

In May 1996, the New England Journal of Medicine published an article reporting the results of a poll of 1,600 critical care nurses. The article concluded that a "comparison of the results reported here with those of [the] survey of physicians in Washington State suggests that critical care nurses in the United States may be as willing to be involved in the practice of euthanasia and assisted suicide as are some physicians." David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 N. Eng. J. Med. 1374, 1377 (1996) (footnotes omitted).

Of the 1139 nurses who responded (71 percent), 852 said they practiced exclusively in intensive care units for adults in the United States. Of these 852 nurses, 141 (17 percent) reported that they had received requests from patients or family members to perform euthanasia or assist in suicide; 129 (16 percent of those for whom data were available) reported that they had engaged in such

practices; and an additional 35 (4 percent) reported that they had hastened a patient's death by only pretending to provide life-sustaining treatment ordered by a physician. Some nurses reported engaging in these practices without the request or advance knowledge of physicians or others. The method of euthanasia most commonly described was the administration of a high dose of an opiate to a terminally ill patient.

Id. at 1374.

A variety of other sources have reported similar kinds of activity. A survey of the practices of physicians in the San Francisco Bay Area conducted from 1990 to 1995 revealed that 53% of the 1995 respondents "reported having granted an AIDS patient's request at least once for assistance in committing suicide. L. Slome, et al., *Attitudes Toward Assisted Suicide in AIDS: A Five Year Comparison Study*, National Library of Medicine (conference abstract available on World Wide Web at <http://sis.nlm.nih.gov/aidsabs.htm>) (December 9, 1996). An anonymous survey conducted by the New Hampshire Medical Society in 1994 revealed that "11 of its member physicians admitted giving dying patients lethal injections and another 22 reported granting terminally ill patients' requests for lethal doses of medication so they could commit suicide." *New Hampshire Physicians Admit Helping Patients Die, Survey Reveals*, Hemlock TimeLines, November-December 1994, at 2.

Of the 597 respondents, 52 percent (310) said if physician-assisted suicide were legal, under certain circumstances, they would prescribe or administer a lethal dose of medication to a terminally ill patient, if requested. Another 19 percent, or 113 physicians, said they would do so even if it were illegal.

Id.; see also Richard A. Knox, *1 in 5 Doctors Say They Assisted a Patient's Death, Survey Finds*, *Boston Globe*, Feb. 28, 1992 at 5.

Although it is an "open secret" that such technically illegal practices are taking place, prosecutions and disciplinary actions against the medical personnel involved have thus far been almost non-existent. When the Journal of the American Medical Association reported what was being done by physicians in Washington, prosecutors in that State and officials of the American Medical Association expressed no shock and made no calls for investigative action. When a distinguished New York physician admitted in the pages of the New England Journal of Medicine that he had assisted a cancer patient to commit suicide by means of an overdose of barbiturates, the New York State Board for Professional Medical Conduct found that "no charge of misconduct was warranted." *New York Will Not Discipline Doctor for his Role in Suicide*, N.Y. Times, August 17, 1991 at L-25. The physician had stated quite clearly in print that his intention had been to give his patient a prescription that she could use to end her life:

As a former director of a hospice program, I know how to use pain medicines to keep patients comfortable and lessen suffering. I explained the philosophy of comfort care, which I strongly believe in. Although Diane understood and appreciated this, she had known of people lingering in what was called relative comfort, and she wanted no part of it. When the time came, she wanted to take her life in the least painful way possible.

...

A week later, she phoned me with a request for barbiturates for sleep. Since I knew that this was an essential ingredient in a Hemlock Society suicide, I asked her to come to the office to talk things over. She was more than willing to protect me by participating in a superficial conversation about her insomnia, but it was important to me to know how she planned to use the drugs and to be sure that she was not in despair or overwhelmed in a way that might color her judgment. In our discussion,

it was apparent that she was having trouble sleeping, but it was also evident that the security of having enough barbiturates available to commit suicide when and if the time came would leave her secure enough to live fully and concentrate on the present. It was clear that she was not despondent and that in fact she was making deep, personal connections with her family and close friends. I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide. We agreed to meet regularly, and she promised to meet with me before ending her life, to ensure that all other avenues had been exhausted. I wrote the prescription with an uneasy feeling about the boundaries I was exploring — spiritual, legal, professional, and personal. Yet I also felt strongly that I was setting her free to get the most out of the time that she had left, and to maintain dignity and control on her own terms until her death.

Although the hospice workers, family members, and I tried our best to minimize the suffering and promote comfort, it was clear that the end was approaching. Diane's immediate future held what she feared the most — increasing discomfort, dependence, and hard choices between pain and sedation. She called up her closest friends and asked them to come over to say goodbye, telling them that she would be leaving soon. As we had agreed, she let me know as well. When we met, it was clear that she knew what she was doing, that she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer. In our tearful goodbye, she promised a reunion in the future at her favorite spot on the edge of Lake Geneva, with dragons swimming in the sunset.

Two days later her husband called to say that Diane had died. She had said her final goodbyes to her husband and son that morning, and asked them to leave her alone

for an hour. After an hour, which must have seemed an eternity, they found her on the couch, lying very still and covered by her favorite shawl. There was no sign of struggle. She seemed to be at peace.

Timothy Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691, 693 (1991). Despite Dr. Quill's clear statement of his intentions and his close involvement in the matter, the New York Board based its decision to drop disciplinary action against him on the ground that "[a]s a treating and prescribing physician, he could not know with certainty what use a patient might make of the drugs he has prescribed. Nor is it within any physician's power or authority to compel a patient to do one thing or another with any prescription. Ultimately, these are decisions left to the patients." *New York Will Not Discipline Doctor for his Role in Suicide*, N.Y. Times at L-25.

In the view of at least one prominent legal-medical commentator, the only thing disturbing about the Quill case was that Dr. Quill felt the need to be so open and honest about his true intentions. In criticizing Oregon's initiative provision legalizing physician-assisted suicide, George Annas has argued:

[N]o changes in current law are needed to legalize the prescription of lethal drugs that have a legitimate medical use to terminally ill patients. Although the clear purpose of Ballot Measure 16 is to encourage this prescription practice, the act of putting this proposal into legislative language may itself create the erroneous impression that current legitimate prescription practices are illegal and should be discontinued.

Ballot Measure 16 may also decrease the number of physicians who are willing to prescribe potentially lethal drugs because the patient must make a request for lethal medication not because he or she will feel more secure if it is available and therefore be able to live better, but only "for the purpose of ending his or her life." Likewise, the physician's purpose

in writing the prescription must be to end the patient's life. In short, under Ballot Measure 16, the physician must agree with an explicit plan of suicide by the patient and must participate in the suicide directly and unambiguously.

George Annas, *Death by Prescription: The Oregon Initiative*, 331 New Eng. J. Med. 1240, 1242 (1994).

In the same way that the physician who gives morphine to hasten the death of a suffering patient may protect himself from a charge of euthanasia by claiming that the morphine was given only to suppress pain, the physician who assists in the suicide of a suffering patient is to be able to protect himself by claiming that he intended only to make the patient "feel more secure." Whether the physician has violated the law by assisting suicide depends upon whether others can prove that he intended to do so. The physician is thus encouraged not to discuss the case with others — even other health care professionals on the treatment team — lest she reveal her true intent.

B. *By seeking to maintain a broad legal distinction between physician-assisted suicide and refusal of life-prolonging treatment, the current regimes have placed patients at a heightened risk of abuse.*

1. *The current regimes, which encourage the widespread, covert practice of physician-assisted suicide, leave that practice totally without oversight and regulation.*

Keeping physician-assisted suicide criminal in theory while winking at it in practice creates an environment rife with opportunities for abuse of patients. Petitioners and the *amici curiae* supporting their position claim that they fear the legalization of physician-assisted suicide because there is no guarantee that it will be practiced only in an environment where patients request it competently, voluntarily, insistently,

on the basis of full information, and as a last resort. What is it about allowing it to be practiced in secret that provides the guarantees that would be lacking if it were practiced in the open? If the answer is "nothing," then we are running all the risks of abuse that petitioners fear and denying ourselves the opportunity to know what is going on and to take corrective action as it becomes necessary. By not knowing, we allow to go unchecked the very abuses Petitioners believe to be intrinsic to the practice of physician-assisted suicide. And we discourage even the open communication among practitioners and their patients that is necessary for good medical practice. The authors of the article regarding the practice of physician-assisted suicide in Washington State observed:

Physicians are often reluctant to discuss these patients with colleagues. Five of the interviewed physicians had not previously discussed their experience with any colleague because of concern for confidentiality or discomfort with the subject. One physician had discussed the experience only after the patient had died; this physician referred the patient to a psychiatrist but did not explicitly mention the reason for the referral and noted, "You don't want everyone aware of it." One physician sought the advice of an ethics committee at the time the request occurred but found the discussion to be so constrained by legal considerations that it was not helpful.

Anthony L. Back, et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA at 923. Fear of legal repercussions may also lead to inadequate discussion with other medical personnel and, most disturbingly, inadequate discussion with the patients themselves. As the author of the article reporting the practices of American critical care nurses reported:

Not all reported instances of euthanasia or assisted suicide were in response to requests or performed with the

knowledge of patients, family members, or surrogates. . . . Although [the] design [of the author's study] precludes a precise assessment of the number of nurses who reported engaging in euthanasia or assisted suicide without a request from either the patient or a surrogate, it could be calculated that at least 58 nurses (7 percent) had done so at least once. Some of these instances may have occurred with the advance knowledge of patients or surrogates and so may be cases of tacit consent. For example, one nurse described her participation in the following way:

Usually the patient has either verbalized or written several requests to have his/her suffering ended. It's like we never planned it, but having developed a relationship with the patient, we both knew when it was time. In some instances, the patient was unconscious, on an opiate drip, which I increased or failed to decrease when vital signs dropped. The only physician I've ever had an agreement with is an oncologist I work with, but it's mostly unspoken.

By a similar calculation, 62 nurses (8 percent) reported at least one instance of engaging in euthanasia or assisted suicide without a request from the attending physician.

David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 N. Eng. J. Med. at 1376. The author concludes:

An argument often made against physicians' performing euthanasia is that patients may come to fear physicians or distrust their motivations. I do not believe the results of this study suggest that patients or the public should fear or distrust critical care nurses. On the contrary, I think a central finding of this study is that these nurses struggle to uphold important personal values under extremely challenging circumstances — often with little support from physicians. National opinion surveys reveal

that the majority of the public support policies that would allow euthanasia under certain circumstances. The results of this study should prompt nurses, physicians, and other health care professionals to examine their practices more openly and collaboratively, with the aim of understanding and reducing disagreement over goals and plans.

Some may take the results presented here as a reason to permit euthanasia in specific circumstances — not just because the demand seems sufficient to result in the practice in any case, but also because by making procedures explicit, one can provide the oversight essential for protecting both patients and health care professionals.

Id. at 1378.

2. *The current regimes, which take decisions to "let patients die" less seriously than decisions to assist suicide, leave the former decisions without adequate oversight and regulation.*

Great risk of abuse is generated as well by the stubborn maintenance of what has become the dangerous distinction between, on the one hand, committing "physician-assisted suicide," and, on the other hand, merely "letting nature take its course." Such a distinction might make sense in those cases where a patient refuses life-saving or life-prolonging treatment on the ground that the treatment itself is offensive or that the treatment would unduly detract from the quality of the time remaining in the patient's life. The terminally-ill patient who refuses treatment for his cancer so that he can enjoy his remaining days without the debilitating side effects of chemotherapy is not choosing to refuse treatment in order to cut short a life that he has come to hate. In such a case it is meaningful to say that a cooperating physician is not assisting a suicide. But when a patient is praying for death to come as swiftly as possible and, in order to bring it on,

—accepts the opportunity to refuse anything that is necessary to keep him alive (food, water, antibiotics, mechanical ventilation, etc.), it is dangerous to pretend that the doctor who turns off the ventilator is not committing an act as serious (morally and legally) as the act of prescribing a lethal dose of pills. Were it not for the physician's decision, the patient would be alive. To maintain that turning off the ventilator is less serious than prescribing the pills encourages physicians to turn off ventilators under circumstances where they would not cause death if they were taking full moral responsibility for their action. See Mildred Z. Solomon, et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 Am. J. Pub. Health 14 (1993) (physicians take decision to turn off ventilator less seriously than decision to assist suicide and take decision to deny placement on ventilator less seriously than decision to turn off ventilator).

Petitioners and the *amici curiae* who support their position clearly take less seriously the decision to remove the ventilator-dependent patient from the ventilator than they do the decision to prescribe the pills. The decision to remove a patient from life support so that she may die is at least as subject to abuse as the decision to prescribe a lethal dose of pills. Yet Petitioners and the *amici curiae* who support their position do not contend that the former decisions require any of the safeguards which they claim must be in place before we legalize the latter. As a result, they put at risk of the abuses they believe are inevitable in the practice of physician-assisted suicide the vast numbers of patients who are removed from life support so that they may die.

Petitioners and their supporting *amici curiae* allege that physician-assisted suicide could lead to the following abuses:

- Coercion or undue influence that would make the patient feel forced into opting for physician-assisted suicide.

- Financial incentives that would influence the patient or caregivers to improperly opt for physician-assisted suicide (especially in this era of limited medical resources and managed care).
- Inadequate determinations of mental competence that would lead to permitting mentally-incompetent individuals to opt for physician-assisted suicide.
- Mistaken diagnoses of terminal illness that would lead to mistaken decisions to opt for physician-assisted suicide.
- Inadequate diagnosis and treatment of depression that would lead to improperly-motivated decisions to opt for physician-assisted suicide.
- Inadequate treatment for pain that would lead to unnecessary decisions to opt for physician-assisted suicide.
- Ineffective communication among medical personnel and with patients that would lead to mistaken decisions in favor of physician-assisted suicide.
- Impatience of medical personnel that may lead to too quick a decision in favor of physician-assisted suicide.

Because they do not take the decision to remove a ventilator-dependent patient from a ventilator as seriously as they do the decision to prescribe a lethal dose of drugs, Petitioners and their supporting *amici curiae* fail to recognize that the listed abuses are at least as likely to occur in the former case as in the latter. The patient who asks to be allowed to die by removal from a ventilator is at least as likely as the patient who requests a prescription for lethal drugs to be making the request because of undue influence, financial pressure, clinical depression, or inadequately treated pain. She is at least as likely to be making the decision with questionable mental competence, on the basis of a mistaken diagnosis or

prognosis, because of ineffective communication with or among medical personnel, or as a result of the impatience of medical personnel with her case. Indeed, one would think that the most likely way for medical personnel to act out impatience with a patient's case or concern regarding mounting costs of medical care would be to recommend that life-sustaining treatment just be stopped. There would be no need to recommend assisted suicide.

Likewise, the risks of an error of diagnosis or prognosis are more severe with removal from life-sustaining treatment than they are with the prescription of the lethal dose of drugs. The patient for whom the drugs are prescribed is likely never to use them if the diagnosis or prognosis turns out to be erroneous.² The patient who opts for terminal sedation will dehydrate to death in seven days time, whether or not the diagnosis or prognosis was accurate.

Moreover, the fact that all decision-makers are encouraged at each stage to treat decisions to "let nature take its course" less seriously than they would treat a decision to prescribe a lethal dose of medication makes the likelihood of occurrence of the various types of abuse greater in the former case than in the latter.

Maintaining the forced distinction between physician-assisted suicide, on the one hand, and termination of treatment, on the other, exacerbates the risk of abuse of patients in many ways. The fact that the boundary between the two types of acts, although theoretically strict and fraught with dire significance, is almost impossible to fix with certainty in practice is one of the causes of inadequate communication among medical personnel and patients. All parties fear that their statements may later implicate them in an act of assisting suicide. This is also a major cause of inadequate treatment for pain. The physician who uses morphine for pain must

² See Anthony L. Back, et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 922 (1996) (noting that 39 percent of terminally ill patients who had asked for and received a lethal prescription never made use of it).

worry, among other things, that someone may later suggest that it was used not just to suppress pain, but also to shorten the life of the patient — thus subjecting her to possible prosecution for assisting suicide. See Miles J. Edwards & Susan W. Tolle, *Disconnecting a Ventilator at the Request of a Patient Who Knows He Will Then Die: The Doctor's Anguish*, 117 Annals of Internal Med. 254 (1992).

The unavailability of physician-assisted suicide may also lead patients to feel pressured to end their lives prematurely by refusing life-sustaining treatment. The AIDS patient who is denied the pills that he could keep at his bedside for the day when he has finally reached the end of his endurance may feel obliged to choose to die much earlier through refusing antibiotics for pneumonia at the time when chance has offered him the opportunity to do so. After all, he cannot be sure when again he will have the opportunity.

But, most fundamentally, maintenance of the distinction between physician-assisted suicide and "letting nature take its course" has exacerbated the risk of abuse by providing the conceptual foundation for a regime in which Petitioners permit patients to die by inaction with none of the protections Petitioners would require for a regime in which physician-assisted suicide were legalized.³ See, for example, J. Andrew Billings and Susan D. Block, *Slow Euthanasia*, 12 J. Palliative Care (forthcoming 1996), in which the authors observe as to terminal sedation:

The slowness of the process — the series of small steps that gradually leads to death — softens the sense of the

³ One of the very few examples of an effort to protect conscious patients who refuse life-prolonging treatment from potential abuse is *Matter of Farrell*, 108 N.J. 335, 529 A.2d 404 (N.J. 1987). Even there, the protections fell woefully short of those Petitioners would require for legalization of physician-assisted suicide. The Supreme Court of New Jersey required only that "two non-attending physicians examine the patient to confirm that he or she is competent and is fully informed about his or her prognosis, the medical alternatives available, the risks involved, and the likely outcome if medical treatment is disconnected." *Id.* at 415.

physician's agency in this instance of mercy killing. The doctor and nurse may not even be nearby when the death occurs. Moreover, many physicians may have written orders on the patient and many nurses may have been involved in the care, thus diffusing responsibility.

A major concern with this form of slow euthanasia, as with many other instances of end-of-life decision making, is that issues of informed consent rarely surface: the patient is not routinely asked whether he or she desires to end life now. Death is brought on smoothly under the beneficent guidance of the medical staff. The practice is carried out openly, but decisions are usually made privately by the primary physician without outside consultation or review. The procedural safeguards that have been proposed for physician-assisted death are not regularly instituted.

Therefore, some instances of slow euthanasia by the morphine drip may be viewed as involuntary euthanasia. Life-terminating acts without explicit requests from dying patients have also been documented in the Netherlands. The existence of such practices supports concerns that we are moving down a slippery slope toward ending life without the patient's fully informed consent.

In summary, slow euthanasia by the morphine drip as described above is a common, long-standing clinical practice at the end of life, but it is not clearly acknowledged as euthanasia. Its widespread acceptance reflects a belief by physicians that this form of euthanasia is an appropriate, humane response to terminal suffering in the last few days of life. Indeed, slow euthanasia may be a way for the physician to do what seems right for the dying in the absence of clear guidelines and supportive legislation for hastening death, perhaps analogous to the use of "slow codes" prior to the legalization of "no codes" and the assertion of patient rights to participate in decisions about cardiopulmonary resuscitation. However, since slow euthanasia is not fully recognized as

euthanasia, it is not subject to appropriate oversight, including review by experts in symptom management and psychosocial care who can assure that appropriate comfort measures have been considered. Moreover, insofar as fully informed consent may not be obtained from the patient, this practice raises the specter of involuntary euthanasia.

Id.

- C. *Important interests, including respect for law and the rule of law, will suffer if this Court permits reinstatement of the irrational legislative regimes at issue here.*

Continued operation of the irrational State legislative regimes involved in these cases comes at great cost to important interests of individual citizens and to important interests of the States themselves.

First, there are the interests of patients, family members, and medical personnel who are forced to endure prolonged, unwanted, senseless, and cruel processes of dying for lack of the option of legalized physician-assisted suicide.

Second, are the interests of the vast number of patients who are put at risk of abuse created by a regime which does not take decisions to cause death by termination of care as seriously as it takes decisions to cause death by physician-assisted suicide.

Third, are the interests of the patients who are put at risk of abuse by a regime which permits illegal physician-assisted suicide to be widely practiced in secret without oversight or regulation.

Fourth, are the interests of those patients who are discriminated against by a regime which makes physician-assisted suicide available only to those who are well-enough connected to find a physician willing to provide such assistance despite the fact that it is illegal. In this respect, the situation is analogous to that which was eliminated by this Court in *Roe v. Wade*, 410 U.S. 113 (1973).

Fifth, are the interests of those physicians and other health care professionals who are made to feel insecure in the practice of medicine because of uncertainty as to which actions are in fact illegal and which are not. These individuals face the risk that their professional and personal lives may at any time be destroyed by an unpredictable exercise of prosecutorial discretion.

Sixth, is the interest of the State in preserving respect for law and the rule of law. To the extent that the State appears to permit physicians to engage in illegal activity with impunity, it sends a message to society that citizens may pick and choose the laws that they must follow. At the very least, it tells physicians and the public as a whole that physicians are above the law. It establishes government by professional aristocracy rather than government by law.

Seventh, is the State's interest in the proper functioning of democratic processes. To the extent that the State permits wholesale violation of an unpopular law, it undercuts citizen incentives for repeal of the law. In this respect, the State legislative regimes involved in these cases are analogous to the Connecticut anti-contraception laws that were struck down in *Griswold v. Connecticut*, 381 U.S. 479 (1965).

Conclusion

For the reasons stated above, the decisions of the United States Courts of Appeal for the Second and Ninth Circuits should be affirmed.

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